

CONSULTATION/REFERRAL REQUEST FORM

To: **Consultant**

From: **Primary physician**

Name: _____

Name: _____

Address: _____

Address: _____

Phone/fax: _____

Phone/fax: _____

Section 1: Requested Action

Consultation

(Please send the patient back for follow-up and treatment.)

- Confirm diagnosis.
- Advise as to diagnosis.
- Suggest medication or treatment.

Referral

(Please provide primary physician with summaries of subsequent visits.)

- Assume management for this particular problem and return patient after conclusion of care.
- Assume future management of patient within your area of expertise.

Section 2: Patient Information

Name: _____

Address: _____

Phone: _____ Date of birth: _____

Tentative diagnosis: _____

Pertinent history, physical and laboratory findings, and special financial considerations:

- See additional information attached.
- Please call me when you have seen the patient.
- I would like to receive periodic status reports on this patient.
- Please send a thorough written report when the consultation is complete.

Signature: _____

PRIMARY PHYSICIAN

Section 3: Consultant's Findings

- I would like to receive periodic status reports on this patient.

Signature: _____

CONSULTANT

Primary physician: Complete sections 1 and 2. Send one copy to the consultant and keep one copy in the patient's chart or in a tickler file.

Consultant: Complete section 3. Return one copy to the primary physician after your initial visit with the patient. Keep one copy for your records.



FPM Toolbox To find more practice resources, visit <https://www.aafp.org/fpm/toolbox>.

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